





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 470

05890

## CERTIFICATE OF DEATH

Reg. Dist. No. 50

## 1. PLACE OF DEATH:

County.....

Calvert

City or town.....

Frostby

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Sarah E. Howard

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

Black

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Joseph Howard

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 18 - 1864

8. AGE:

Years

Months

Days

If less than one day

80

6

23

hrs.

min.

9. Birthplace

Oliver, Maryland

(Town, county, and state)

10. Usual occupation

School-teacher

11. Industry or business

FATHER

12. Name

Name.....

Eunice Savoy

MOTHER

13. Birthplace

Birthplace.....

Maryland

14. Maiden name

Maiden name.....

Evelyn Johnson

15. Birthplace

Birthplace.....

Maryland

16. Informant

Informant.....

Wm. J. Savoy

Address

Address.....

Frostby, Md.

17. Burial

Burial, cremation, or removal. Which?.....

Date thereof.....

(month) (day) (year)

Cemetery or crematory

Cemetery or crematory.....

Eastern M. E. Church

Location

Location.....

Oliver, Md.

18. Funeral director

Funeral director.....

P. Seavel

Address

Address.....

Prince Frederick, Md.

19. (Date rec'd by registrar)

Date rec'd by registrar.....

9/11

18

45

A.D.E.S. Costa

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Calvert

City or town.....

Frostby

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 10 1945 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....

19.....

and that I last saw h..... alive on

19.....

Immediate cause of death.....

Pulmonary Hemorrhage

DURATION

1/2 hour

Due to.....

Pulmonary Cancer

3 mos.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

E. S. Costa, M. D., physician

M. D. or other

Address.....

Solomons, Md.

Date signed

9/11/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (H)

05889

## CERTIFICATE OF DEATH

Reg. Dist. No. 52

## 1. PLACE OF DEATH:

County.....

Cooperstown  
Chesapeake Beach

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Lodge

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

George Klein

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

M

6.(b) Name of husband or wife.....

Mary I. Klein

7. Birth date of

deceased (mo., day, yr.)

1886

6.(c) If alive, give age

years

8. AGE:

Years  
59

Months

Days

It less than one day

hrs. min.

9. Birthplace.....

Phila. Pa

(Town, county, and state)

10. Usual occupation.....

Merchant

11. Industry or business

Philip Klein

12. Name.....

Germany

13. Birthplace

Unknown

14. Maiden name.....

Unknown

15. Birthplace

Mrs. Burgess Chaney

16. Informant.....

Chesapeake Beach

Address

Burial

Date thereof  
(month) (day) (year)

17. Burial

Cemetery

Cemetery or crematory

Mt. Harmony

Location

W. H. Hutchins

18. Funeral director

Swigge

Address

June 8, 1945

G. Hutchins

19. (Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Calvert

City or town..... Chesapeake Beach

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

June 7, 1945, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 5, 1945, to June 7, 1945

and that I last saw him alive on

Immediate cause of death..... Coronary

disease

DURATION

1 hr.

Due to.....

Due to.....

Other conditions.....

None

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

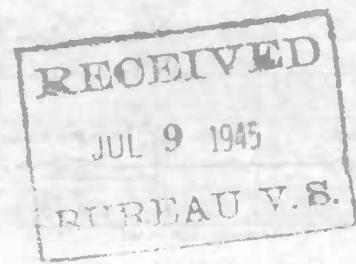
Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Prince Frederick Date signed..... June 8, 1945



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05891

## CERTIFICATE OF DEATH

Reg. Dist. No. 50

## 1. PLACE OF DEATH:

County *Calvert*City or town *Prince Frederick*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *7 days*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Anne V. Litch*4. Sex *F* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *W*6. (b) Name of husband or wife *William A. Litch*7. Birth date of deceased (mo., day, yr.) *Sept 23, 1853* 6. (c) If alive, give age *years*8. AGE: Years *91* Months *8* Days *15* If less than one day *hrs. min.*9. Birthplace *Charles County, Md.*10. Usual occupation *House*11. Industry or business *John Harkness*MOTHER FATHER 12. Name *John Harkness*13. Birthplace *Md.*14. Maiden name *Ans. E. Simmons*15. Birthplace *Md.*16. Informant *Miss Lydia Litch*Address *Prince Frederick, Md.*17. Burial *Burial* Date thereof *June 11, 1945*

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Central*Location *Barstow, Md.*18. Funeral director *D. A. Harkness & Sons*Address *Mt. Royal, Md.*19. *6-11 1945* *J. M. King*

(Date rec'd by registrar) (Signature) (Registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.*County *Calvert*City or town *Prince Frederick*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *520*

(If rural, give LOCATION)

2.(a) If veteran, name war *WW*3. (b) Social Security Number *20*

## MEDICAL CERTIFICATION

20. DATE OF DEATH *June 8, 1945*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Rebet

19.45 to 19.45

and that I last saw her alive on

June 6, 1945

Immediate cause of death *Cardiac*

Failure with general

anaesthesia

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

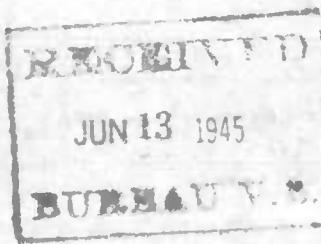
Means of injury

Injured at work?

23. SIGNATURE *Page & Isb*

M. D. or other

Address *Prince Frederick*Date signed *6/11/45*



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1302

05892

## CERTIFICATE OF DEATH

Reg. Dist. No. 52

## 1. PLACE OF DEATH:

County.....

City or town.....

Calvert

Huntingtown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Joseph. Daniel Lyons.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white

M

6. (b) Name of husband or wife.....

Edna Lyons

7. Birth date of

deceased (mo., day, yr.)

Oct. 19, 1881

6. (c) If alive, give age

years

8. AGE:

Years      Months      Days      If less than one day

63

8

0

hrs.

min.

9. Birthplace.....

Md

(Town, county, and state)

10. Usual occupation.....

Lumber Business

11. Industry or business

Polk Lyons

12. Name.....

Polk Lyons

13. Birthplace

Md

14. Maiden name.....

Sarah E. Hardenly

15. Birthplace

Md

16. Informant.....

Harry Hutchins Jr.

Address

Sevings, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

6 10 45

(month) (day) (year)

Cemetery or crematory.....

Miranda Memorial Cemetery

Location.....

Huntingtown

18. Funeral director.....

W. H. Hutchins &amp; Sons

Address.....

Sevings

19. June 9 1945

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Calvert

City or town.....

Huntingtown

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

7 June 1945 at 8 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2 June 1945 to 10 June 1945

and that I last saw him alive on 7 June 1945

Immediate cause of death.....

Hypertension  
cardiac vascular and disease

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

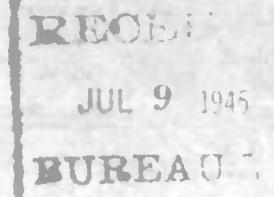
Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Date signed.....



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

T 05893

## CERTIFICATE OF DEATH

Reg. Dist. No. 50

## 1. PLACE OF DEATH:

County Calvert

City or town Barstow

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 51

Hospital, Institution, or street address where death occurred:

Now long in hospital or institution?

## 3. (a) FULL NAME

Ruth Bowen Mornett

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

## B. (b) Name of husband or wife

Griffith Mornett

6. (c) If alive, give age 41 years

7. Birth date of

deceased (mo., day, yr.)

May 25, 1904

8. AGE:

Years

Months

Days

If less than one day

41

0

14

hrs. min.

## 9. Birthplace

Adelina, Md

(Town, county, and state)

## 10. Usual occupation

House

## 11. Industry or business

FATHER

12. Name

Somerset Bowen

13. Birthplace

Calvert Co., Md

14. Maiden name

Lillie G. Sedwick

15. Birthplace

Calvert Co., Md

16. Informant

Mrs. Oscar Bowen

Address

Barstow, Md

17. Burial

Date thereof June 11, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Central

Location

Barstow, Md

## 18. Funeral director

A. A. Harkness &amp; Son

Address

Mutual, Md

19. 6-11

19. 45

(Date rec'd by registrar)

I. N. King

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Calvert

City or town

Barstow

(If outside city or town limits, write RURAL and give nearest town)

Street No.

200

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

No

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

9 June 1945, at 7:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 April 1945 to 9 June 1945, and that I last saw her alive on 8 June 1945

## Immediate cause of death

Carcinoma of lungs

DURATION

Due to: Carcinoma of breast.

## Due to:

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide...

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

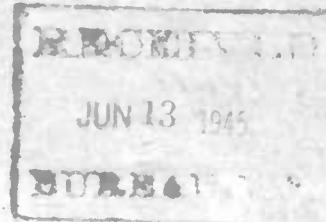
## Means of injury

Injured at work?

## 23. SIGNATURE

George M. King, M.D. or other

Address Huntington, Md. Date signed 9 June 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 45-8

75894

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred:

Chest Hospital

How long in hospital or institution? 3 weeks

## 3. (a) FULL NAME

Joseph Earl Raby

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White

single

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

October 9 1930

8. AGE:

Years

Months

Days

If less than one day

14

7

29

hrs.

min.

9. Birthplace

Upper Marlboro, Md. George Co. Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER

FATHER

12. Name

Carroll Willmer Raby

St. Marys Co. Md.

13. Birthplace

St. Marys Co. Md.

14. Maiden name

Carroll B. McKenzie

15. Birthplace

Md. George Co. Md.

16. Informant

Mrs. Alancha B. McKenzie

Address

29 Jefferson St. Annapolis, Md.

17. Burial

Date thereof June 9, 1945

(Burial, cremation, or removal. Which?)

Cemetery or crematory

St. Marys

Location

Annapolis, Md.

18. Funeral director

B. J. Hooper

Address

Annapolis, Md.

19. June 9 1945

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County Anne Arundel

City or town

Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No.

29 Jefferson (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 2D. DATE OF DEATH

June 6, 1945, at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 12, 1945, to June 6, 1945, and that I last saw him alive on June 6, 1945.

Immediate cause of death

Pneumonia

DURATION

3 months

Due to

Pneumonia of Nasopharynx, Jan 1945

Due to

Other conditions

(Include pregnancy within 3 months of death)

## Major findings or operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

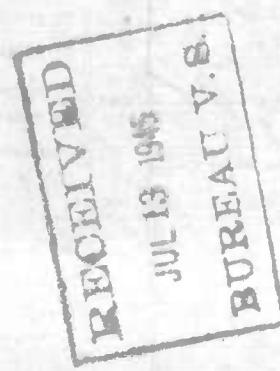
23. SIGNATURE M. D. or other

Address

Page J. Lett, M.D. Date signed 6/6/45







## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *BA*

05896

CERTIFICATE OF DEATH ★Reg. Dist. No. *51*

## 1. PLACE OF DEATH:

County

*Calvert*

City or town

*Blunckirk**7 md.*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

*life*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Catherine H. Wilson*

4. Sex

*F*

5. Color or race

*C*

6. (a) Single, married, widowed, or divorced

*X*

6. (b) Name of husband or wife

*Pat Wilson*6. (c) If alive, give age *72* years

7. Birth date of deceased (mo., day, yr.)

*Mar. 17, 1874*

8. AGE:

*71*

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

*MD*

(Town, county, and state)

10. Usual occupation

*Domestic*

11. Industry or business

12. Name

*Julia T. Wilson*

13. Birthplace

*MD*

14. Maiden name

*Mary Cook*

15. Birthplace

*MD*

16. Informant

*Pat Wilson*

Address

*Blunckirk, MD*

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof *6-7-45*  
(month) (day) (year)

Cemetery or crematory

*Wall's Creek*

Location

*Calvert*

18. Funeral director

*P.C. Denevill*

Address

*Prince Frederick, MD*19. *6-4-45*

(Date rec'd by registrar)

*CV. Jarvis*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *MD*

County

*Calvert*

City or town

*Blunckirk**7 md.*

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

*6-4-1945* at *9:30 AM*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Dec 1944* to *June 1945*and that I last saw ~~her~~ alive on *May 20* 1945

Immediate cause of death

*Obstruction Myocarditis*

DURATION

*3 m/s*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Duly sworn before me this *6th* day of *June* 1945, at *9:30 AM*Address *Prince Frederick, MD* Date signed *6-4-45*

